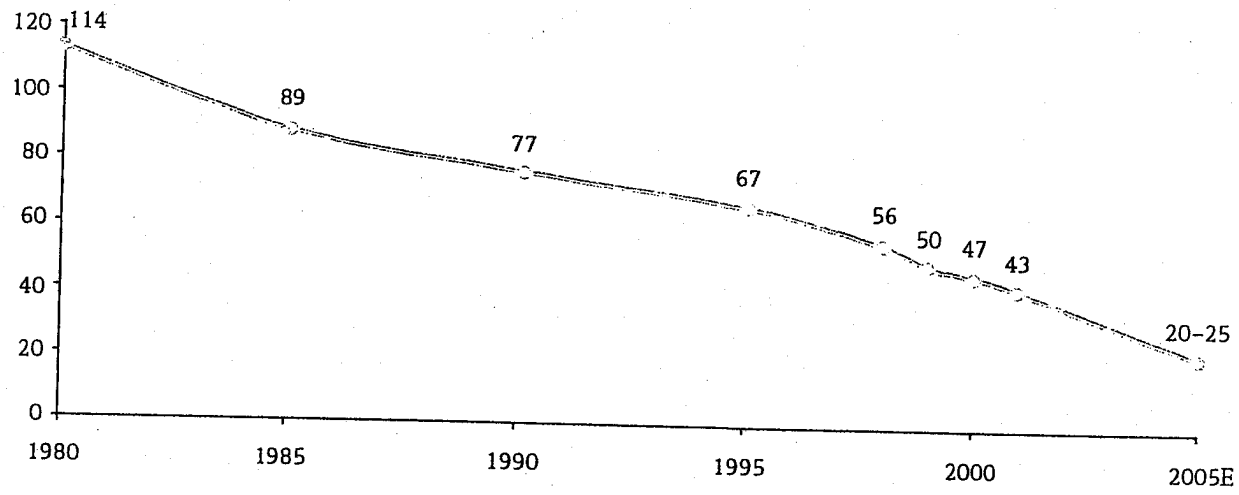
Two popular techniques health plans are using to fight the squeeze include expansion to gain economies of scale, and accessing the public equity markets. These strategies can make operations more efficient, and better enable health plans to make the significant investments described earlier in this paper. Combined, these actions could have the potential to put health plans on a "virtuous cycle" for ongoing growth.

Increasing a health plan's member base can drive scale economies-expenditures can be spread across more members, and more funds are generated to make the investments described above. Increased scale can also help stabilize earnings, enabling a health plan to better withstand downturns in individual segments of their businesses. Many plans have gained scale by acquiring other, generally smaller, health plans. This is evidenced by multiple health plan combinations over the past 10 years, and the unprecedented reduction in the number of Blue Cross Blue Shield plans–from 114 to 43–over the past 20 years.

Number of Operational Blue Cross and or Blue Shield Health Plans



Source: Conning & Company, *The Blue Cross and Blue Shield Plans: Past, Present and Future*, 2000; BCBSA data for years: 1980, 1985, 1990 and 2001.

When a health plan acquires another health plan that competes in the same market, there is potential for an additional advantage. Studies have shown that companies across industries perform better if they are able to maintain a strong market share relative to their competition (relative market share).

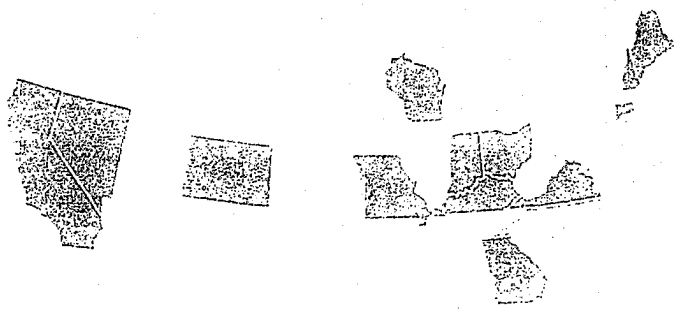
As the health insurance industry consolidates, this phenomenon also presents a threat to health plans' competitiveness. A health plan's relative market share diminishes as the health plans with which it directly competes (those in its current markets, as opposed to those in adjacent or remote markets) consolidate. If it wishes to protect its relative market share in home markets, a health plan needs to participate in the consolidation. It needs to act when local, direct competitor health plans come up for sale. Of course, doing so requires capital.

In addition to bolstering overall financial stability through economies of scale, many health plans realize the need to access capital in order to make required investments. Some are increasing access to capital through the public equity markets. A common approach is to convert to for-profit status, and then issue

shares for sale to the public. There has been a wave of such conversions, primarily among Blue Cross Blue Shield plans, with more planned. About 79 million Americans carry Blue Cross Blue Shield cards; approximately one third of those are members of Blue Cross Blue Shield plans that are either for-profit plans, or are considering a for-profit conversion.

Blue Cross Blue Shield Health Plan Conversions
(Completed and Planned Conversions as of December 2001)

	Members Carrying BCBS Cards*	% of Total BCBSA Lives
For-profit Plans	16.9M	21%
Considering or Pursuing Conversion	11.4M	14%
Total	28.3M	35%



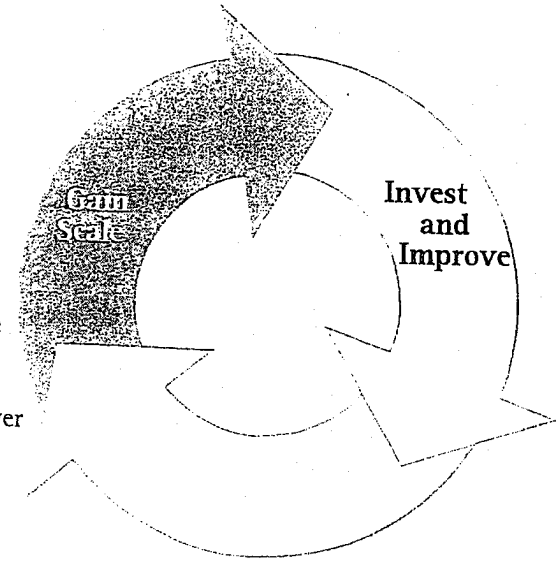
* Blue Branded Members only.
Source: Health plan public information; BCBSA enrollment data as of September 30, 2001.

The objective for taking these actions is to establish a "virtuous cycle": increased scale and access to capital drives cost reduction and investment in service improvements. These, in turn, increase a plan's attractiveness to members and employers, which in turn attracts new customers, further increasing scale, and so on.

A "Virtuous Cycle" for Health Plans

Gain Scale
Increase member base
- Increase revenues
- Position health plan for increased investment

Compete Better
Use advantages to enhance competitive position, e.g.:
- Reduced rates, or lower rate increases, due to lower operating costs
- Improved and/or differentiated services



Invest and Improve
Exploit the advantages available through increased scale
- Reduce operating costs by aggressively pursuing economies of scale – e.g., integrating core systems and operations
- Invest more in innovative and/or differentiating services and products – e.g., eCommerce, consumer-focused initiatives, improved operations

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These national trends are playing out in the Mid-Atlantic region, with rising health care costs, significant investment requirements, increased scale of competitors, for-profit conversions and some health plans closing down or being acquired.

Each of these trends is affecting CareFirst specifically. For example, over the past three years, CareFirst experienced average annual health care cost increases of 7.8% in its Commercial HMO business, and 10.0% in its Maryland Small Group business. Like other health plans, CareFirst is investing to improve its service to customers, and to comply with changing regulatory requirements.

Plans in the region are participating in the industry consolidation: Coventry Health Care purchased all or parts of 11 health plans in three years; Aetna acquired U.S. Healthcare, NYLCare, and Prudential Healthcare. Several smaller plans have closed down or been acquired, including the George Washington University Health Plan, Innovation Health, and the QualChoice of Virginia Health Plan. Blue Cross and Blue Shield of Virginia, now known as Trigon, converted to for-profit status and went public in 1997. CareFirst itself represents the affiliation of Blue Cross Blue Shield plans serving Maryland, the Washington, D.C. region, and Delaware.

We believe that to maintain its competitiveness in the face of these industry pressures, CareFirst would benefit from a substantial increase in scale and capital access. One of the options available to CareFirst to do so quickly would be to combine with a large for-profit health plan.

Accenture helped CareFirst estimate that a scale of $11-$16 billion in annual revenue could greatly aid it in maintaining competitiveness over the next several years. This range was estimated based on our assessment of CareFirst's capital needs.

This scale would be very difficult for CareFirst to achieve through home-market expansion (i.e., through incremental growth). Just being able to support the strategic investments would require substantial market share expansion, adding as many as 1.4-3.1 million members to its 2000 year-end membership. Another option would be to expand beyond CareFirst's present boundaries; however, CareFirst's Blue Cross Blue Shield brand license limits CareFirst to competing with the Blue Cross Blue Shield brand in its current geographic markets. And, while less formal affiliations can provide some benefits to health plans, they generally limit the opportunities to achieve economies of scale compared with true mergers. Since CareFirst lacks sufficient capital to be an acquirer on the scale that it targets, combining with another health plan would likely be structured as a sale of CareFirst to another health plan.

Market forces appear to be driving Blue Cross and Blue Shield plans to pursue mergers and to access the public equity markets. As more and more health plans do so, plans that lack these advantages could find competing more difficult over time. Because a merger and access to public equity markets could make CareFirst a stronger company, and because CareFirst currently possesses a strong market position, the timing appears favorable for CareFirst to make such a change.

Industry analysts see the conversion of Blue Cross Blue Shield plans as not only wise, but necessary in some cases. Samuel Levitt, a leading analyst and author of a recent report by Conning & Company says:

"...the economic realities of healthcare leave them no choice [but to convert to for-profit and access the public equity markets]*...we think it's not in general a very friendly environment for not-for-profits."*

A. M. Best, which analyzes the health insurance industry and rates specific organizations, published an article last year that stated:

"The consolidation of Blue Cross & Blue Shield plans surged during the 1990s and will continue to sweep the insurance industry well into the next century. Whether it be in response to the regulatory environment, a need for improved efficiencies or simply company survival, mergers and acquisitions have become a primary issue for most insurance companies."

Later in the article they state:

"As consolidations continue and the need for access to capital increases, the conversions to for-profit status will rise symmetrically."

Investment bank Shattuck Hammond states in its Spring 2001 State of the HMO Industry report:

"In order to sustain earnings growth, national HMOs will return to the acquisition market. In addition, we believe that they will become more aggressive in their acquisition valuations."

And later:

"Rapid Blue Cross Blue Shield consolidation expected to continue...low profitability and limited access to capital have been the two primary factors driving the consolidation. The strong share price performance by the publicly-traded Blue Cross Plans as well as additional Blue Cross Blue Shield IPOs and for-profit conversions should further facilitate the consolidation through increased access to capital and diminished geopolitical obstacles."

The timing appears favorable for CareFirst to make such a change because it is profitable and has built a strong market position. As a result, CareFirst could command an attractive price from a prospective buyer. In the past four years, the combined market share of CareFirst's three largest competitors in the region increased from 22% to 37%. Should CareFirst's competitors continue their recent improvements, CareFirst's currently strong negotiating position (by virtue of its strong market position) could be threatened.

V. Impacts on Availability, Accessibility and Affordability

To assess the potential impact of CareFirst's proposed conversion to for-profit status and merger with WellPoint on the availability, accessibility and affordability of health care services, we reviewed the merger agreement, researched similar experiences in other states (particularly WellPoint's prior actions), and queried WellPoint regarding its intentions. We assessed the potential impact of the proposed transaction against the baseline of CareFirst's business as of December 2001 where possible, the most recent time period available to us. The key steps undertaken are summarized below.

Approach to Prepare this Community Impact Analysis

1. *Identify Potential Influencers* – We identified the aspects of CareFirst's business that could influence availability, accessibility and affordability of health care services. We first considered those parts of CareFirst's business that directly touch CareFirst's members and the communities in which CareFirst operates. We also considered other parts of CareFirst's business that could influence decision-making on the member- and community-touching business components. Taken together, these influencers include:

   A. Business Purpose and Foundations – Would the change from non-profit to for-profit form, coupled with the creation of Public Benefit Obligation (PBO) foundations, be likely to affect availability, accessibility, and affordability?
   B. Competition – Would the transaction be likely to give CareFirst additional market power that could affect availability, accessibility, and affordability?
   C. Availability and Accessibility of Doctors and Hospitals – Would CareFirst's doctor and hospital networks or the overall supply of doctors and hospitals in CareFirst's jurisdictions be impacted?
   D. Medical Management Policies and Practices – Would the rules by which members access care be likely to change as a result of the transaction?
   E. Operations – Would service be affected?
   F. Products – Is it likely that products would be restricted or enhanced as a result of the transaction?
   G. Pricing – Is it likely that prices (health care insurance premiums) would change as a result of the transaction?
   H. Governance – Would the change in control impact availability, accessibility, and affordability?
   I. Regulation – Would CareFirst's conversion to a for-profit change regulatory oversight and thereby impact the availability, accessibility, or affordability of health care?

Medical loss ratio is sometimes used as a gross indicator of accessibility and affordability. As medical loss ratio can be influenced by many factors unrelated to accessibility and affordability, such as accounting practices and mix of business, we chose instead to examine the key drivers of medical loss ratio more directly related to accessibility and affordability. These include:

- Availability and Accessibility of Doctors and Hospitals
- Medical Management Policies and Practices
- Operations
- Pricing (health care insurance premiums)

2. *Review Proposed Transaction Specifics* – We were provided with a copy of the "Agreement and Plan of Merger By and Among WellPoint Health Networks Inc., CareFirst, and Congress Acquisition Corp." signed and dated November 20, 2001 ("Merger Agreement"). We conducted a non-legal analysis of the terms and conditions of the Merger Agreement to determine if any terms and conditions could affect any of the areas listed above for health care services in Maryland, Delaware and Washington, D.C.

3. *Analyze the Experience of Health Plans in Similar Situations* – We examined the performance of Blue Cross Blue Shield plans in two other states that have converted to for-profit status and merged. Plans examined include WellPoint's Blue Cross of California and Blue Cross Blue Shield of Georgia. We looked at these health plans to understand how a for-profit health plan is likely to behave before and after conversion, and also because they specifically involve CareFirst's proposed merger partner, WellPoint. In addition to merging with WellPoint, Blue Cross Blue Shield of Georgia is another East coast plan, like CareFirst, and similar in scale as measured by membership (approximately 2.0 million members compared to CareFirst's 2.5 million members in the Mid-Atlantic service area, and 3.12 million members overall).

4. *Apply Insights From other Situations to CareFirst's Situation* – Once we gathered insights from the similar situations, we applied them to CareFirst's situation in order to determine the potential impact on the availability, accessibility, and affordability of health care in the Mid-Atlantic region.

5. *Query WellPoint Management* – The potential impact of the transaction on the availability, accessibility, and affordability of health care depends, in part, on the policies and practices that WellPoint intends to implement post-transaction. In order to understand WellPoint's intentions in this regard, we queried WellPoint management on several specific points. Quotes from WellPoint management's responses are included in the Report below and in the Appendix.

6. *Draw Conclusions* – Finally, we drew conclusions regarding the potential impact of the merger on the availability, accessibility, and affordability of health care in the Mid-Atlantic region based on the insights from other markets, the application of the insights to CareFirst's situation, WellPoint query responses, and Accenture's understanding of the health care industry.

Findings

The purpose of this section is to provide the findings of our analysis for each business area assessed. Please see Appendix V., Section Data Sources, Assumptions and Methodologies for detail on how these findings were developed. These findings are as follows:

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A. Business Purpose and Foundations –

Would the change from non-profit to for-profit form, coupled with the creation of Public Benefit Obligation (PBO) foundations, be likely to affect availability, accessibility, and affordability?

In the event CareFirst converts to a for-profit enterprise, overall availability, accessibility and affordability of health care services could improve. CareFirst's incentives would change, but Public Benefit Obligation (PBO) foundations created in each jurisdiction could make a positive and sizable impact and may assume some or all of the non-profit purposes historically associated with Blue Cross and Blue Shield plans.

Many Non-Profits are Currently Behaving Like For-Profits

The change from non-profit to for-profit corporate form will not, *per se*, change CareFirst's operating behavior. In many ways, nearly all Blue Cross Blue Shield plans today operate like for-profit health plans. Specifically, nearly all make decisions based on the business merits of any particular issue, with an eye toward making their products as attractive as possible to customers (both individuals and groups). They are forced to act in this manner in order to survive and compete effectively with for-profit health plans that

also behave this way. As a result, most Blue Cross Blue Shield plans, including CareFirst, do not play a central role today as an instrument of government or local community health policy.

For example, in most cases, non-profit health plans do not fill the role of "insurer of last resort". In a competitive market, a health plan could not survive filling that role, if its competitors did not play that role also. CareFirst is not statutorily required to be an "insurer of last resort" in Maryland. While CareFirst does participate in programs designed to address the needs of the under- and uninsured (e.g., Maryland's SAAC program), such participation is neither limited to CareFirst specifically nor to non-profits generally. Eligibility for participation in these programs is independent of an organization's form (i.e., non-profit or for-profit). Decisions regarding participation in these programs are generally made on the basis of the terms of each program and the resulting business benefit. It appears reasonable to assume that CareFirst will make decisions with regard to participation on that basis. We found no terms in the Merger Agreement that signify an intent to make decisions on any other basis.

One exception to the general trend of non-profit health plans not filling the role of "insurer of last resort" is in the District of Columbia, where a non-stock, non-profit corporation is required to offer an open enrollment program to citizens of the District[A-1]. For-profit entities are permitted to offer similar programs, but are not required to do so. CareFirst's open enrollment membership in the District has been small. As of November 1, 2001, CareFirst's Washington, D.C. plan had 678 members in an open enrollment program[A-2]. Should CareFirst convert to for-profit form, it could opt to continue to offer this open-enrollment program. A more likely outcome, however, would be that such a program would be funded through the Public Benefit Obligation Foundation formed in Washington, D.C. by the transaction (discussed later in this section). Given the small number of people using the open enrollment option, and the significant sums to be realized from this transaction, the foundation to be established could have more than sufficient resources to maintain health care availability, accessibility and affordability currently provided by CareFirst through the open enrollment mechanism.

In order to effectively compete with for-profit health plans, CareFirst's decision-making behavior must parallel that of a for-profit health plan. As a result, CareFirst's ability to serve as an instrument of health policy today is necessarily very limited. We see evidence of this in CareFirst's exit from the Medicare+Choice and Medicaid Risk programs. One reason CareFirst was unable to continue in these programs was that its network providers (i.e., physicians, hospitals and other caregivers) found participation to be economically unattractive and withdrew from CareFirst's networks[A-3]. Many health plans, including many Blue Cross Blue Shield plans, have exited these programs because the programs have led to financial losses[A-4]. The health plans exiting the programs made rational business decisions to not burden the rest of their customers with the cost of covering these money-losing programs. As a result, many Blue Cross Blue Shield plans have been less able, over time, to serve segments (e.g., the poor and the aged) that are frequently the focus of public health policy.

CareFirst's Incentives Would Change, but the Foundations May Assume Some or All Non-Profit Purposes

As a for-profit, CareFirst would continue to focus on the organization's competitive viability and financial strength, as it does today. However, CareFirst's first priority would be to earn a return for shareholders. A change in corporate form would require CareFirst to introduce more stringent financial discipline in order to ensure more predictable, stable earnings, in response to shareholder demands. Availability, accessibility, and affordability may be affected to the extent that CareFirst's minor role today in implementing

Maryland, Delaware and Washington, D.C. health policy was not replaced by the foundations to be established.

The real opportunity to affect the availability, accessibility and affordability of health care in the affected communities comes from the public benefit assets given to the various Public Benefit Organizations in the conversion. In Maryland, the Maryland Health Care Trust, with the Maryland Health Care Foundation as its trustee, is statutorily created to receive charitable assets from converting non-profit entities to be used to meet the health care needs of Marylanders[A-5]. Although Delaware and Washington, D.C. do not have similar legislation in place, historical precedent from the conversion of other Blue Cross and/or Blue Shield plans leads us to assume that Delaware and Washington, D.C. will also form foundations to receive funds from the Public Benefit Obligation coming from CareFirst's conversion[A-6]. The $1.3 billion payment for CareFirst would be divided among the three jurisdictions (Maryland, Delaware, and Washington, D.C.). It is reasonable to expect that the PBO funds in Delaware and Washington, D.C. would be used for health purposes similar to those intended in Maryland. In the absence of any definitive legislation or regulation in Delaware or Washington, D.C. on the topic, this is what we have assumed for the purposes of our Report.

Overview of Other PBO Foundations
(Foundations Created as a Result of a Conversion of a BCBS Plan)

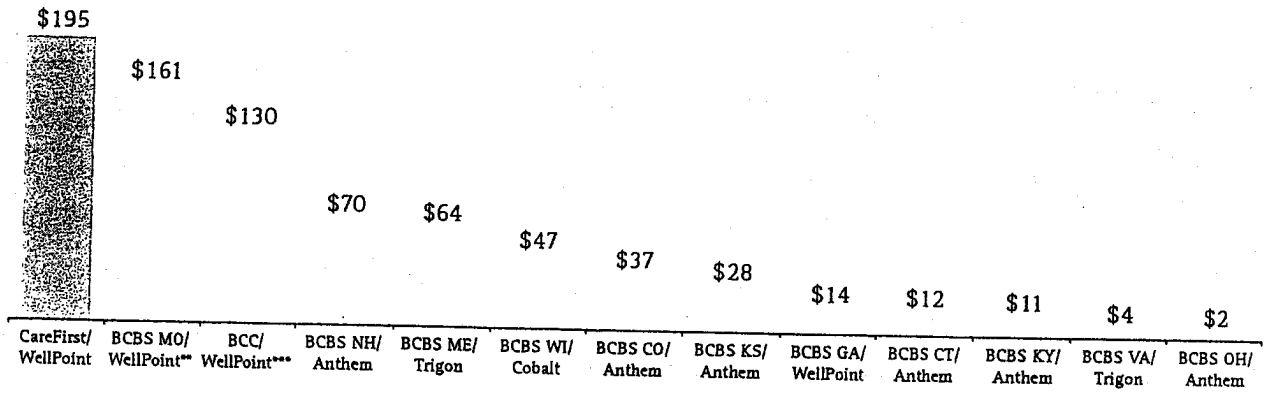
Area	Specific Focus	Foundation
Access to Health Care	Access to health care, multicultural health and general health Improve access for uninsured Payment for health care services Fund unmet health care needs Managed care, the uninsured, health policy and quality Health care needs of uninsured and under-insured Serve underserved or uninsured	The California Endowment* Maine Health Access Foundation Sunflower Foundation (KS) Foundation for a Healthy Kentucky California HealthCare Foundation Missouri Health Foundation* Anthem Foundation of Connecticut
Quality	Improve health care Improve health and reduce the burden of illness Improve health care through capital projects, equipment and technology	HealthCare Georgia Endowment for Health (NH) Caring for Colorado
Research	Support for human research	Commonwealth Health Research Fund (VA)
Medical Education	Funding for state medical schools and public health	Wisconsin United for Health*
Oral Care	Preventive oral care and prevention of family violence	The Anthem Foundation of Ohio

* Largest health care foundation in state.
Source: Grant Makers in Health, *A Profile of New Health Foundations*, March 2001; Health plan press releases; Community Catalyst website; Foundation Center website; Foundation websites.

The resulting PBO foundations would represent a new vehicle by which the needs of the under- and uninsured could be fulfilled. Due to the large size of the PBO foundations, $1.3 billion among Maryland, Delaware, and Washington, D.C., the foundations' ability to fulfill these purposes could well exceed CareFirst's existing ability to do so, since CareFirst's ability to be an instrument of each jurisdictions' health policy today is limited by its need to control costs in order to remain price competitive. On a per capita basis, the PBO foundations, considered together across Maryland, Delaware and Washington, D.C.

would be the largest ever created, based on the conversion of a Blues plan, in any state[A.7].

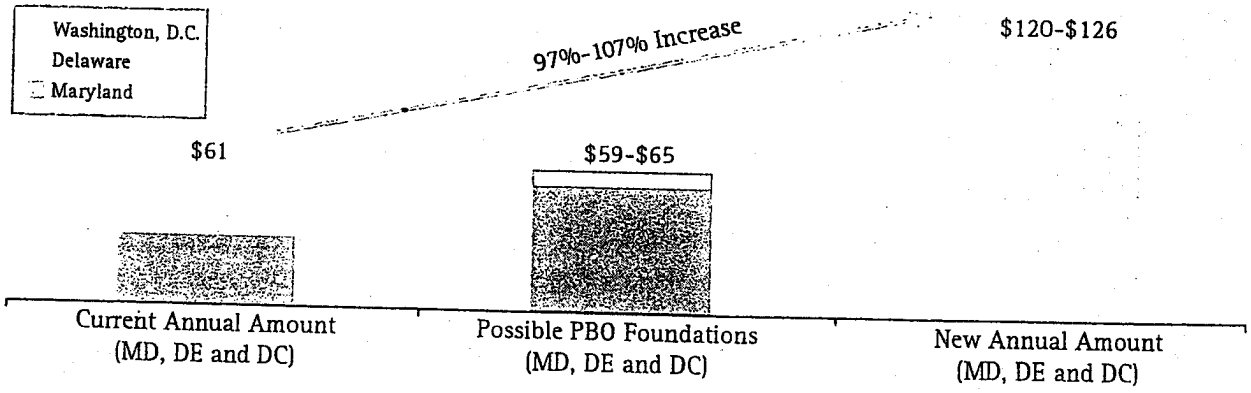
Per Capita Value of BCBS Foundations Created by For-Profit Conversion*



* Calculations are based on most recent value of foundations publicly reported. Per capita values were arrived at by dividing the current size of the foundation by the state/ jurisdiction population that the foundation services. Values of foundations created by publicly traded companies may be stock-based and will fluctuate with stock price changes.
** Value of foundation includes pending WellPoint merger.
*** BCC created two foundations which are combined for this analysis.
Source: Grant Makers in Health, *A Profile of New Health Foundations*, March 2001; Health plan press releases; Community Catalyst website; Foundation Center website; Foundation websites; U.S. Census Bureau.

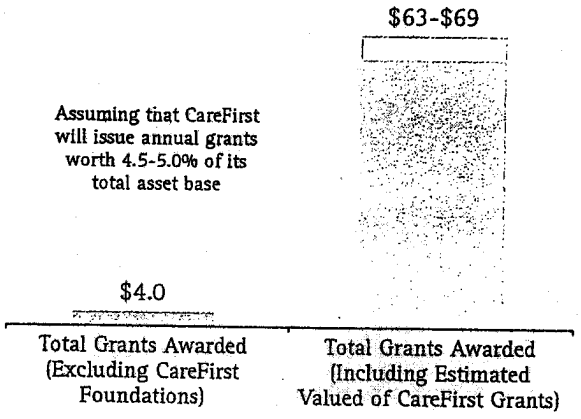
On the basis of our estimates, the addition of these PBO foundations could increase the annual amount of health care grants awarded in Maryland, Delaware, and Washington, D.C. by 97%-107%[A.8, A.9, A.10].

Annual Amount of Health Care Grants Awarded in MD, DE and DC*
(2000, $ in Millions)

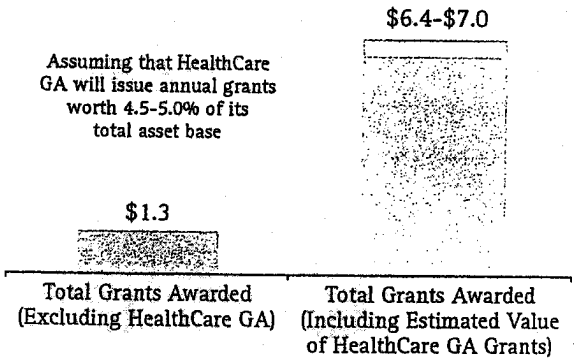


* The search set is based on The Foundation Grants Index (circa 2000), which includes grants of $10,000 or more awarded to organizations in MD, DE or DC by a sample of 1,015 larger foundations. Foundations are located nationally. For community foundations, only discretionary grants are included. Grants to individuals are not included in the file.
Source: The Foundation Center, customized report sourced from The Foundation Grants Index.

Annual Amount of Grant Awards, 2000
(Converted Foundations in MD, DE and DC only, $ in Millions)



Annual Amount of Grant Awards, 2000
(Converted Foundations in GA only, $ in Millions)



Source: Grant Makers in Health, *A Profile of New HealthCare Foundations*, March 2001, The Foundation Center by using The Foundation Directory Online.

Non-profit foundations are required to grant as much as 5% of their holdings to maintain their federal non-profit tax status, and can choose to grant more (note: some of the 5% annual payout is expected to go towards the costs of administering the foundation). For example, the California Endowment, one of the foundations created as a result of the conversion of Blue Cross of California to a for-profit business entity, awarded $197 million in grants, or approximately 5.3% of its assets, in fiscal year 2000[A.11]. These grants were awarded to support the Endowment's primary goals of Multicultural Health, Health and Well-Being and Access to Health Care. $74 million of the grant money awarded was given to CommunitiesFirst, a grant-making program designed to find community-driven solutions to persistent and emerging health challenges facing the underserved in California. Access to health care services for underserved populations has always been a primary focus of the California Endowment. Since its inception in 1996, the Endowment has awarded more than 70 grants totaling more than $60 million to support community clinics in all areas of the state.

Across all PBO foundations in CareFirst's service area, a grant rate of 4.5% to 5% of the $1.3 billion translates to $58.5 to $65.0 million spent annually on health care across the three jurisdictions. To illustrate the magnitude of this funding, if it were solely dedicated to extending Medicaid coverage to individuals that qualify for federal matching funds, the foundations alone could insure an additional 46,000 to 52,000 people in Maryland, Delaware, and Washington, D.C.[A.12] Further, the foundations may have more flexibility than CareFirst has had to direct the dollars to areas where they are needed most, because unlike CareFirst, the foundations would not be in a competitive position with other health plans.

The large collective size of the foundations is a direct result of the attractiveness of CareFirst as a business. CareFirst's current strength, combined with state budget deficits for health care programs, make the current time opportune for the proposed transaction.